Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments Surveyor: 07178 As a result of a Standard Licensing Survey, Verification Visit and Complaint Investigation conducted by Surveyors #31903, #13203 and #07178 at Ark Haven For The Elderly, 27 violations were issued. 1 uncorrected violation from SOD #9KUT13, dated 6/20/2012. 1 uncorrected violation from SOD #IBSV11, dated 10/4/2012. 9 repeat violations from SOD #9KUT11, dated 2/24/2011 and SOD #9KUT12, dated 1/23/2012. Under the statutory provisions of Wis. Stat. § 50.033(3), a $200 revisit fee is being assessed for this follow-up to the licensing visits of SOD #9KUT13, dated 6/20/2012 and SOD #IBSV11, dated 10/4/2012.	{N 000}		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 158	Continued From page 1 report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Surveyor: 07178 Based on record review and interviews, the CBRF did not investigate an allegation of abuse and did not take immediate steps to ensure the safety of all residents. The CBRF did not investigate and document allegations of abuse of a resident by a caregiver. The CBRF did not maintain documentation of the investigation. On 12/21/2012 and 12/30/2012, Resident #2 made allegations of caregiver misconduct. The facility did not investigate these allegations and did not take steps to ensure the safety of all residents. Findings include: Surveyor #07178 reviewed the record of Resident #2 on 2/19/2013. Resident #2 was admitted to the facility on 7/20/2012 with diagnoses including ETOH Abuse, Seizure Disorder, Paralysis and Spinal Cord Injury. According to Froedert Hospital Discharge papers, on 12/21/2012, Resident #2 was taken to Froedert Hospital. Resident #2 arrived at Froedert intoxicated and stated he had a fight at his group home. It was noted that Resident #2 reported that "staff at the group home had assaulted him." He indicated that he did not want to return to the facility. He stated that the	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 158	Continued From page 2	N 158		

caregiver had drove his wheelchair around the corner, grabbed the patient, pushed him into the wall and banged his head into the wall several times. Froedert examined Resident #2 and the record contained further documentation from Milwaukee County Behavioral Health Team arrived at Froedert to assess Resident #2.

A referral to Elder Abuse was made by Froedert staff.

A second Froedert Emergency Department visit form was dated 12/30/2012. This report noted Resident #2 arrived at the emergency room and was diagnosed with Intoxication. Resident #2 stated he "had facial pain after he had fallen out of bed 4-5 times." According to the hospital "History and Physical dated 12/30/2012, the emergency room nurse had contacted a caregiver at Ark Haven and it was reported by the caregiver that Resident #2 had locked himself in his room, when he came out of his room he wanted to pick a fight with another resident. She rolled him back to his room and fell out of his wheelchair into his bed. Another staff came over and put him in bed. Nurse says that he fell out of the bed 4-5 times after that, had to be put back into bed after being found on floor. They are unsure if he hit his head."

Resident #2 reported to the emergency room that "he was hit repeatedly in head." "Staff reports falls. Patient has a bump above the left eye.

Resident #2 reported two separate incidents of abuse by caregivers of the facility. On 12/21/2012, the hospital documented that the resident reported "female staff member took patient around the corner, so no one could see and rammed my head into the wall 4 times."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 158	Continued From page 3 On 12/30/2012, the hospital documented "Patient said he was pushed out of his wheel chair by female staff but female staff reported to EMS (Emergency Medical Service) that patient fell. Social Work consult requested to assess patients living environment and level of safety. Patient lives at Ark Haven.....Writer spoke with Manager A and she said that this is patient's third group home placement and has had to leave other placements due to combative behavior. Patient was treated and released at FMLH ED on 12/21/2012 for same complaints...." On 2/19/2013, Surveyor #07178 interviewed Resident #2. Resident #2 stated that a caregiver, by the name of (Caregiver N), or something similar to that, had banged his head against the wall. This happened in December 2012 and Administrator A knows about it. Resident #2 stated he reported this to Administrator A as did the Froedert Hospital staff. On 2/19/2013, Surveyor #07178 asked Administrator A if she was aware of the allegations made by Resident #2. Administrator A stated that one of the incidents happened at the change of shift but that she did investigate it. When asked which staff worked during the time frame Resident #2 had gone out to the hospital, Administrator A stated she did not recall. When asked about the staff schedules for the time frames, Administrator A stated she fax the schedules to the department. Surveyor #07178 reqested the investigation into the allegations on 12/21/2012 and 12/30/2012. Administrator A stated she would fax the information to the department by 2/22/2013. As of 2/28/2013, the department did not receive any information.	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 158	Continued From page 4 On 2/26/2013, Surveyor #07178 interviewed Case Manager J and RN Case Manager I. Both Case Manager J and RN Case Manager I stated they never received a call from Administrator A regarding the allegation made by Resident #2. They indicated that they do not know who the caregivers were that worked with Resident #2 on 12/21 and 12/30/2012 when the allegations were made. RN Case Manager I stated that on 1/3/2013 she observed a healing laceration to Resident #2's top of head. She also observed a bruise on the back of his right leg and the right buttocks. RN Case Manager I stated the size is 2-1/2 dollar size bruises. Resident #2's record did not contain any documentation related to the laceration and brusing. The facility did not investigate two allegations of caregiver misconduct and did not document the investigation. The facility did not ensure that residents were safe from potential abuse pending the results of Administrator A's investigation. Cross Reference: DHS 83.15(3)(a) Administrator Supervise Daily Operation DHS 83.(1)(i) Behavior Management DHS 83.42(1) Maintain Record	N 158		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Surveyor: 07178	N 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 165	Continued From page 5 Based on record review, the CBRF did not send a written report to the Department within 3 working days when Resident #4 fell out of bed, was sent to the hospital for sutures, then was admitted to the hospital, required an amputation and did not return to the facility. Findings include: On 2/19/2013, Surveyor #07178 reviewed the record of Resident #4. Resident #4 was admitted to the facility on 8/17/2012 with a diagnosis including Severe Dementia, Peripheral Edema and Mild Cellutis. The record contained an admission assessment which documented that Resident #4 did not have any open areas, "skin intact." The assessment was signed by Administrator A. The record did not contain any information regarding a fall on 9/12/2012 or 9/13/2012. On 2/20/2013, Surveyor #07178 reviewed the hospital record for Resident #4. According to a hospital record review, Resident #4 was transferred to the hospital on 9/13/2012 following a fall from his bed when he sustained a leg laceration. The hospital record noted that the laceration was 10cm long on the right leg. The hospital record noted that the assisted living facility reported Resident #4 had a fall witnessed by his roommate on 9/13/2013. The hospital record noted Resident #4 arrived with a "gapping [sic] wound on his right lower leg." According to the Emergency Department report, Resident #4 required sutures to the 10cm long wound on the right lower leg.	N 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 165	Continued From page 6 When the hospital staff assessed Resident #4 they noted Resident #4's "left leg was cold to touch, mottled left foot and was purplish to the ankle. No pulses noted, no pulses noted via Doppler in Emergency Department." A Vascular physician consultation was ordered and on 9/13/2012, an above the knee amputation was ordered. On 9/17/2012, the amputation was completed. Resident #4's final diagnosis was "Gangrene Embolism and Thrombosis of arteries of lower extremity. Rhabdomyolysis and Systemic Inflammatory response syndrome unspecified." On 2/21/2013, Surveyor #07178 asked Administrator A if she had investigated the fall and if she had reported the fall resulting in serious injury requiring hospitalization to the Department. Administrator A stated Resident #4 did not fall and he was admitted to the facility on 8/17/2012 with the leg wound. As of 2/28/2013, no additional information was provided to the Department.	N 165		
N 175	83.13(1)(c) Maintain employees' schedules. The CBRF shall maintain documentation of all of the following: Employees ' schedules as required under s. HFS 83.36(2). This Rule is not met as evidenced by: Surveyor: 13203 Based upon record review, interview and observation the facility did not ensure that they maintained an employee schedule as required under DHS 83.36(2). As evidenced by: Surveyor #13203's review of Staff E's record, on	N 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 175	Continued From page 7 2/19/2013, reflected a date of hire of 1/15/2013. Surveyor's review of Staff E's record reflects that she has not received training in fire safety. Per DHS 83.23 requirements Staff E must be directly supervised by either Administrator A and/or or by a qualified resident care staff until she has completed all required training. Surveyor #13203 requested employee schedules from Administrator A on 2/19/2013. Administrator A said the employee schedules were on a computer and would be provided to the department by 2/22/2013. As of 2/28/2013, the department has not received employee schedules from Administrator A. Surveyor was unable to confirm if Staff E is currently being directly supervised; however, a review of staff schedules at 2 additional facilities licensed by the licensee and observations at 3 of 3 facilities licensed by the licensee reflect one caregiver per shift.	N 175		
N 187	83.13(2)(d) Dated menus retained for 60 days. Dated menus shall be retained for 60 days. This Rule is not met as evidenced by: Surveyor: 13203 Based upon record review and interview, the facility did not ensure that it maintained menus for 60 days. As evidenced by: Surveyors requested facility menus for the period of October of 2012 through February 2013 from Administrator A on 2/19/2013. Administrator A provided the surveyor's with one week of menus for each month. The remaining weeks were not	N 187		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 187	Continued From page 8 provided to the surveyors as requested. As of 2/28/2013, no additional information was provided to the department.	N 187		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Surveyor: 07178 Based on record review, staff interview, resident interview, case manager interviews and observations, the Licensee continued to fail to ensure the CBRF and its operation complies with all laws governing the CBRF. The Licensee has not maintain compliance with all requirements as reflected in previous 5 survey visits completed by the Department. Findings include: The facility is licensed as a eight-person, Class CNA, non-ambulatory, community-based residential facility, that serves residents with Advanced Age and Irreversible Dementia/Alzheimer's, Mental Illness/ED, Developmentally Disabled and Physically Disabled. History of non-compliance: SOD #9KUT11, dated 2/24/2011- 8 Repeat Violations DHS 83.15(3)(a) Administrator Supervise Daily	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 196	Continued From page 9 Operation DHS 83.35(3)(a) Comprehensive Service Plan DHS 83.37(1)(h) Psychotropic Medication Reviews DHS 83.37(2)(d) Administration of Injectable's DHS 83.38(1))(i) Health Monitoring DHS 83.44(1)(c) Venting Clothes Dryer DHS 83.47(2)(e) Other Evacuation Drills DHS 83.47(3) Fire Inspection SOD #9KUT12 dated 1/23/2012 - 8 Repeat Violations DHS 83.15(3)(a) Administrator Supervise Daily Operation DHS 83.35(3)(a) Comprehensive Service Plan DHS 83.35(3)(d) Service Plan Developed with Parties Involved DHS 83.37(1)(h) Psychotropic Medication Reviews DHS 83.37(1)(i) PRN Psychotropic Medication DHS 83.37(2)(d) Administration of Injectable's DHS 83.38(1))(i) Health Monitoring DHS 83.42(1) Maintain Resident Record See SOD#9KUT13, dated 6/20/2012 DHS 83.35(3)(d) Service Plan Developed - Uncorrected Violation SOD #IBSV11, dated 10/4/2012 DHS 83.38(1)(g) Health Monitoring - Uncorrected Violation On 2/29/2013, Surveyors #31903, #13203 and #07178 entered Ark Haven for The Elderly to conduct a Standard Survey, Complaint Investigation and Verification Visit to SOD #9KUT13 dated 6/20/2012 and SOD #IBSV11 dated 10/4/2012. Per Plan of Correction to SOD #IBSV11 completed and signed by Administrator A, the facility indicated they were in compliance	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 196	Continued From page 10	N 196		

as of 2/15/2013 to all violations listed in SOD #IBSV11. As a result of the 2/29/2013 visit, 27 violations were issued. The facility did not sustain compliance based on the current visit and past 4 surveys.

During the entrance conference, surveyors met with Administrator A to explain the purpose of the visit and request that the following records be made available: all resident records; a list of residents with admission date; a list of employees with date of hire; schedule of staff from September 2012 thru February 2013; Medication Reviews; all Safety Code Reports for the year 2011 and 2012 which included fire inspections, smoke and heat inspections, furnace inspections, fire and evacuation drills; copies of menus from September 2012 through February 2013. Surveyors stated to Administrator A that the information needed to be available on 2/19/2013. When documents were not provided on 2/19/2013, Administrator A was to fax them to the department by 2/22/2013. On 2/19/2013, surveyors clearly stated that any additional information not provided by Administrator A would need to be received by the Department by 2/22/2013. Administrator A stated she understood that 2/22/2013 was the final date to provide the information to the department.

As of 2/28/2013, the department did not receive all requested information from Administrator A. These documents included staff schedules, menus, medication reviews, safety code reports, inspections and drills.

Administrator A provided a list of residents residing in the home, with admission dates yet inconsistencies noted with the actual number of residents residing in the home and names of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 196	Continued From page 11 residents in the home. As a result of the 2/28/2013 survey visit, the following was noted: SOD #IBSV12, dated 2/28/2013 27 Violations DHS 83.12(2)(a) Caregiver Investigate DHS 83.12(4)(c) Report Incident with Serious Injury DHS 83.13(1)(c) Maintain Employee Schedule DHS 83.13(2)(d) Dated Menu Retain DHS 83.14(2)(a) Licensee Comply with Laws DHS 83.15(3)(a) Administrator Supervise Daily Operation DHS 83.17(1) Licensee Conduct Caregiver Background Checks DHS 83.17(2)(e) Employee Screen for Communicable Disease DHS 83.25 Continuing Education DHS 83.35(2) Temporary Service Plan DHS 83.35(3)(a) Comprehensive Service Plan DHS 83.35(3)b) Service Plan Developed with Parties Involved DHS 83.35(3)(d) Service Plan Updated DHS 83.35(5)(a) Initial Evaluation Evacuation DHS 83.37(1)(h) Scheduled Psychotropic Medication DHS 83.37(1)(i) PRN Psychotropic Medication DHS 83.37(2)(d) Other Administration Given DHS 83.38(1)(g) Health Monitoring DHS 83.38(1)(i) Behavior Management DHS 83.41(3)(b) Food Safety DHS 83.42(1) Maintain Resident Record DHS 83.44(1)(b) Separate Laundry Storage DHS 83.44(1)(c) Clothes Dryer Vented DHS 83.44(2)(a) Room Clean DHS 83.45(1)(e) Electrical, Mechanical and Water Supply DHS 83.47(2)(e) Other Evacuation Drills	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 196	Continued From page 12 DHS 83.47(3) Fire Inspection As identified above, Licensee Y did not ensure the CBRF and its operation complied with all laws governing the CBRF as exhibited by 27 current violations, inability to sustain compliance and a history of uncorrected and repeat violations and the actions of Administrator A as outlined above and in DHS 83.15(3)(a) Administrator Responsibilities.	N 196		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Surveyor: 07178 Initially cited on standard licensure visit. Refer to SOD #9KUT11, dated 2/4/2011. Uncorrected on verification visit. Refer to SOD #9DUT12, dated 1/23/2012. Corrected on verification visit. Refer to SOD #9KUT13, dated 6/20/2012. Repeat violation, on this current standard licensure visit. Refer to SOD #IBSV12, dated 2/28/2013. Based on staff interview, interviews with legal guardians, case managers and residents, record reviews and a review of the CBRF past history of	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 214	Continued From page 13	N 214		

non-compliance, the administrator did not supervise the daily operations of the CBRF.

The facility is licensed as a eight-person, Class CNA, non-ambulatory, community-based residential facility, that serves residents with Advanced Age and Irreversible Dementia/Alzheimer's, Mental Illness/ED, Developmentally Disabled and Physically Disabled.

On 2/19/2013, Surveyors #31903, #13203 and #07178 conducted a Standard Survey, Verification Visit and Complaint Investigations at Ark Haven For The Elderly. Surveyors met with Administrator A to discuss the purpose of the visit. Surveyors requested a complete list of employees who are current employees of the facility, list of residents with admission dates, the fire and evacuation drills from 2011 to present, the smoke and heat inspection and testing reports from 2011 to present, copies of staff schedules from 10/2012 through 3/1/2013, furnace inspections, and menus from 10/2012 through 3/1/2013.

On 2/19/2013, Administrator A initially stated that the current census of the home is 7. Administrator A then stated it was 6. Administrator A then provided a list of the following residents of the facility: Resident #1, #2, #3, #5, #7 and #8. Resident #6 was not included on that list. Administrator A brought the records of Resident # #1, #2, #3, #5, #7 and #8 to the surveyors to review. Administrator A did not include Resident #6's record when bringing the facility records to the surveyors on 2/19/2013.

Surveyors observed Resident #6 walking around the facility. Surveyors asked Caregiver B how

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 214	Continued From page 14 many residents are currently residing in the facility. Caregiver B stated 7. Surveyor #07178 asked Caregiver B when did Resident #6 move into Ark Haven For The Elderly as he had previously resided at Ark Haven For The Elderly II. Caregiver B stated she believed it was about 2 weeks ago as Administrator A closed Ark Haven For The Elderly II (did not officially surrender license though). Surveyor #07178 asked Caregiver B for the record of Resident #6. Caregiver B opened the medication closet and pointed to his record. Administrator A did not disclose to the surveyors that Resident #6 was transferred to Ark Haven For The Elderly and that he was a current resident of Ark Haven For The Elderly. On 2/19/2013, Surveyors informed Administrator A that the following documents needed to be reviewed by the department as the records were not available in the facility; Administrator A stated she would fax them to the department by 2/22/2013: The copies of staff schedules from 10/2012 through 3/1/2013, furnace inspections, and menus from 10/2012 through 3/1/2013. Documentation related to Resident #1 which included February 2013 wound clinic care notes, any and all physician notes/visits from February 2013, all progress notes from 10/2012 to the present. Documentation related to Resident #2 which included psychotropic medication reviews, progress notes, 2 investigations related to caregiver misconduct, fall risk assessment, individual service plans.	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 214	Continued From page 15 Documentation related to Resident #4 which included individual service plan, all progress notes, skin assessments, assessment of his legs and feet, fall assessments, and any additional physician notes to the present. On 2/20/2013, Surveyor #07178 requested the documentation related to Resident #6 which included evacuation assessment and notification of the transfer. The temporary individual service plan. Additionally requested were the menus and staff schedules. At the time of the request, Administrator A stated she would provide the information on 2/22/2013. Surveyors requested facility menus for the period of October of 2012 through February 2013 from Administrator A on 2/19/2013. Administrator A provided the surveyors with one week of menus for each month. The remaining weeks were not provided to the surveyors as requested. Surveyor #13203 requested employee schedules from Administrator A on 2/19/2013. Administrator A said the employee schedules were on a computer and would be provided to the Department by 2/22/2013. As of 2/28/2013, the Department has not received employee schedules from Administrator A. On 2/19/2013, Surveyor #13203 and Surveyor 07178 requested a roster of all current employees and the personal file of all current employees. Surveyor #13203's review of the roster and employee personal files reflected the names of 4 employees: Staff B (Caregiver), Staff C (Caregiver), Staff D (Caregiver) and Staff E (Caregiver).	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 214	Continued From page 16 Surveyor #13203's review of medication administration records (MAR) for Resident #7 reflected the initials [initials omitted]. Surveyor observed that these initials were identified as Staff K (Caregiver). Staff K's initials appeared on the MAR through out the month of January and February and reflected that Staff K had most recently passed medications on 2/17/2013. Staff K was not identified on the employee roster nor was Surveyor #13203 provided with Staff K's personal record as requested. As of 2/28/2013, the department has not received any of the documents requested on 2/19/2013 to complete the survey, verification visits and complaint investigations. Per Interviews: On 2/26/2013, Surveyor #07178 interviewed Case Manager J (Resident #2's Case Manager.) Case Manager J stated that she had attempted to schedule meetings with Administrator A, at times and dates chosen by Administrator A, then canceled by Administrator A. Case Manager J stated to Surveyor #07178 that she is not contacted by the facility regarding any change of condition for Resident #2, her client and has difficulty reaching Administrator A to discuss issues. Case Manager J indicated she learns of changes when she completes her visit to the facility, and has to ask caregivers on duty for updates. Case Manager J indicated that she was not told of Resident #2's allegations of abuse by the facility, but learned when reading Resident #2's hospital discharge summaries. Case Manager J indicated she was not notified that Resident #2 had gone to the emergency room until the hospital had called her to inform her of the visit. Case Manager J expressed concern that Resident #2's record at the facility does not	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 214	Continued From page 17 contain all necessary information related to care and treatment, such as physician visits. On 2/26/2013, Surveyor #07178 interviewed RN Case Manager I (Nurse for Resident #2.) RN Case Manager I stated Administrator A did not tell her about the two allegations of abuse made by Resident #2 by a facility caregiver. RN Case Manager I stated she is not updated by Administrator A nor facility staff until she (RN Case Manager I) visits Resident #2 at the facility and asks staff on duty for updates. RN Case Manager I indicated that she had requested Administrator A install a grab bar (to assist Resident #2 in transferring to the toilet) in Resident #2's bathroom. She was told by Administrator A that she did not want to install the assistive device if he was going to move. Per Case Managers, no discharge was in progress. On 2/26/2013, Surveyor #07178 interviewed Case Manager H (Case Manager for Resident #6.) Case Manager H stated he was not told by facility staff or Administrator A that Ark Haven For The Elderly II had moved his client into Ark Haven For The Elderly. (Facility located next door.) Case Manager H stated this move was done without his knowledge and he was concerned as this facility seems more restrictive. You need to press a door bell, wait for someone to open the door as it is locked from the outside. When asked about facility up dates related to Resident #6's progress or change in condition, Case Manager H stated he is not contacted by the facility and that when he visits, he has to ask staff members on duty for updates. On 2/27/2013, Surveyor #07178 interviewed Case Manager L (Case Manager for Resident #1.) Case Manager L stated one year ago,	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 214	Continued From page 18 1/2012; Resident #1's safety box in his room was broken. Administrator A stated she would replace it. It was not replaced until 1/2013. She did not understand why it took one year for the item to be replaced. Case Manager L was concerned at his representative payee does bring him money on a monthly basis. She also expressed the concern that Administrator A did not ensure that Resident #1 made it to his medical appointments. On 2/27/2013, Surveyor #07178 interviewed RN Case Manager O (Nurse for Resident #1.) She expressed concern that physician visit documentation is not in Resident #1's record when she completes her visits. She indicated that she has to ask caregivers on duty for updates during the visit, as she is not contacted by the facility. Facility Nurse/Nurse Consultant: On 2/19/2013, Surveyors #31903, #13203 and #07178 interviewed Administrator A about quarterly psychotropic medication reviews. Administrator A stated that she had a nurse/consultant (Nurse Consultant F) who completed the reviews. Administrator A stated that she had attempted to reach him this past month but was not able to reach him. Administrator A informed Surveyors #13203 and #07178 that her Nurse Consultant F visits the home one time per week or as needed but had not been to the facility for the past 3 weeks although remains on her payroll. Administrator A stated that Nurse Consultant F completes the medication reviews but that she did not have the reviews at the facility. Administrator A stated she had not recently spoken to Nurse Consultant F regarding the reviews but that since he had not been to the facility in the last 3 weeks, she hired a medical director to complete the reviews in the	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 214	Continued From page 19 future. Administrator A stated he remains on her payroll. Surveyor #07178 called Nurse Consultant F on 2/25/2013 to discuss the reviews and inquire about his employment status at Ark Haven For The Elderly. Nurse Consultant F did not answer the phone so Surveyor #07178 left a message to return the call. As of 2/28/2013, no return call was received. ALRD AA (State Regional Director) called Nurse Consultant F on 2/25/2013. ALRD AA left a message to return the call as he did not answer the phone. As of 2/28/2013, no return call was received. As of 2/28/2013, the Department has not received any psychotropic medication reviews. Cross Reference: DHS 83.14(2)(a) Licensee Responsibilities DHS 83.17(1) Complete Background Checks and Employee DHS 83.25 Continue Education DHS 83.35(3)(a) Comprehensive Service Plan DHS 83.35(3)(d) Annual Individual Service Plan DHS 83.37(1)(h) Psychotropic Medication Review DHS 83.38(1)(g) Health Monitoring DHS 83.42(1) Maintain Resident Record	N 214		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. HFS 12.	N 219		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 219	Continued From page 20 A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. HFS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. HFS 12. This Rule is not met as evidenced by: Surveyor: 07178 Based on record review and staff interview, the facility did not ensure that at the time of hire, the licensee conducted and documented a caregiver background check. The licensee shall not employ, contract or permit a person who has been convicted of the crimes, or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats. and DHS 12, Appendix A, unless the person has been approved under the Department's rehabilitation process as defined in DHS 12. Findings include: On 2/6/2013, the Department received information that Person Z (former Administrator) is currently working at the Ark Haven For The Elderly facilities which included Ark Haven For the Elderly, Ark Haven For The Elderly II and Ark Haven For The Elderly III. Person Z is prohibited, by court order, from working in or for an entity that receives public funds. A background check should have revealed this limitation. The licensee corporation and facility retained the services of Person Z on a full-time consultative basis. Person Z and the licensee corporation's board of directors should have known of this limitation and condition of Person Z's extended supervision with WI Department of Corrections.	N 219		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 219	Continued From page 21 A department review of the Biennial Report noted the following: Ark Haven For The Elderly was initially licensed by the Department on 3/14/2002. The facility was licensed to provide care to the following client groups: Advanced Aged, Developmentally Disabled, Physically Disabled, Irreversible Dementia/Alzheimer's, Emotionally Disturbed/Mental Illness and had a designation in the State APIS database and public directory as being able to accept Public Funding. The home is licensed to provide care to 8 residents. Their initial application, dated 12/17/2002, had an "x" through the box designated "yes" next to the question "Does the Community based Residential Care Facility have a contract with a county human services or social services department to serve Medicaid eligible individuals?" A review of the Department Issued License Continuation Biennial Report dated 2/10/2011, noted the following client groups are served: Advanced Aged; Developmentally Disabled; Emotionally Disturbed/Mental Illness; Irreversible Dementia/Alzheimer's and Physically Disabled. The facility documented: "Does the Community Based Residential Facility have a contract with any agency to service individuals eligible for public funding?" The facility documented "No." Board Member Y dated the report 2/14/2011 and signed the Biennial Report. A review of the Department Issued License Continuation Biennial Report dated 1/25/2013 noted the following client groups are served: Advanced Aged; Developmentally Disabled; Emotionally Disturbed/Mental Illness; Irreversible Dementia/Alzheimer's and Physically Disabled.	N 219		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 219	Continued From page 22 The facility documented: "Does the Community Based Residential Facility have a contract with any agency to service individuals eligible for public funding?" The facility put a checkmark, documenting "No." Administrator A dated the report 2/5/2013 and signed the Biennial Report. A review of the Wisconsin Circuit Court Access (WCCA), case # 2009CF005545, shows Person Z was convicted of felony theft by false misrepresentation and served time in Taycheedah Correctional Instiution; released from prison on August 28, 2012. Person Z was charged with defrauding the Wisconsin Shares program (state's taxpayer-financed child care program) of over $950,000. According to a Milwaukee Journal article dated 9/1/10, this fraud amount was the largest of the child care subsidy fraud cases in Milwaukee. http://www.jsonline.com/watchdog/watchdogreports/101990848.html Person Z is ordered to pay $450,000 in restitution and is on extended supervision through the Department of Corrections. Additionally, court records on WCCA pertaining to a sentencing hearing on 9/10/12 indicate: "Court imposed the following conditions of extended supervision 1) obtain/maintain employment but may not be employed at day care or any entity that obtains public funds." Prior to the conviction in 2010, the board of directors for the licensee corporation executed a resolution to remove Person Z from the board and administrator position. Administrator A, Person Z's daughter, was at that time appointed to the position of Administrator of all three facilities. The board of directors knew of the charges and knew that having Person Z as board president and administrator would become problematic in terms of their eligibility to maintain	N 219		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 219	Continued From page 23 licensure. According to information provided by Community Care Organization, an organization which provides public funding (Family Care, which is a state Medicaid waiver program), Ark Haven For The Elderly facilities had their public funding contract with this Managed Care Organization on 1/31/2012. According to Community Care, the Ark Haven For The Elderly facilities reapplied for a public funding (Family Care) contract again recently and were denied participation on 2/13/2013. Assisted Living Regional Director (ALRD) AA contacted Person BB, contract manager for Milwaukee County Department of Family Care. Person BB confirmed they have been and continue to contract with Ark Haven for the placement of individual Family Care members. Family Care is a public funding source, a federally approved waiver of the Medicaid program that is comprised of both state and federal dollars. Documentation of the facility's Family Care contract and payments was received by ALRD AA. A screen print-out from the county's MIDAS database shows this Ark Haven facility contract as "active" in status. A copy of their current contract/provider identification # 391592513 was also acquired; contract was effective 1/1/11 and clearly shows intent of the county Managed Care Organization and Ark of the New Covenant Church Inc to enter into a purchase of service contract for services within the Family Care benefit package. The amount paid to Ark Haven between 1/1/12 and 12/31/12 was $150,594.68 according to a claims summary. The current amount paid perday for each of the 4 members/residents placed at Ark Haven is	N 219		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 219	Continued From page 24 $110.37, for both room & board and supportive services. One resident is authorized for this payment through 4/30/13, a second resident is authorized through 7/31/13, and the remaining two are authorized through 8/31/13. Other residents at Ark Haven were placed by Milwaukee County Behavioral Health Division, and are participants in the Community Support Program. The CSP program provides case management and assistance in locating housing for persons with severe and persistent mental illness. There are public funds involved in the CSP (for treatment and case management); however, it has not yet been confirmed if any public funds were used to pay Ark of the New Covenant Church for the residents placed at the Ark Haven facilities. Per written information provided by Board Member X on the 2011 and 2013 Biennial Reports, the Ark Haven Facilities did not receive public funding. Per information from Community Care, Community Care did have a contract with the Ark Haven facilities prior to 2012. Milwaukee County Department of Family Care currently has a contract with Ark Haven facilities and has been paying Ark Haven monthly for the placements of individual members enrolled in Family Care. The information provided on the last two biennial reports was false. On 2/19/2013, Administrator A informed Surveyors #31903, #13203 and #07178 that Person Z did work for Ark Haven For the Elderly, Ark Haven For The Elderly II and Ark Haven For The Elderly III. Administrator A stated that her office was in the church across the street from the facilities. Administrator A provided a job description for Person Z which indicated the	N 219		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 219	Continued From page 25 following: "Position-Operation Consultant" "Program-Ark Haven For the Elderly" "General Summary: The operation consultant is directly responsible to the Administrator for the operation of Ark Haven for the Elderly. The Operation Consultant will assess the current status of internal procedures and strategies and enhance the overall operation of the company. Principle Duties and Responsibilities: Develop systems to ensure day to day operations is meeting its full potential. Take Inventory of supplies and food production Ensure the upkeep and maintenance of facility grounds Distribution of mail to the offices and homes Under the supervision of the Director/Administrator the consultant is to provide a monthly budget sheet and system Provide and arrange for appropriate intervention services" On 2/19/2013, Administrator A informed Surveyors #31903, #13203 and #07178 that Person Z was not working, but that she does "consulting on accounting and management." Her office is across the street and she is at the facilities as needed. Administrator A stated that Person Z works 5 days per week and comes to the facilities as needed. Administrator A stated that Person Z had been working at the facilities for more than 6 months. Administrator A provided the most recent Background Disclosure Form signed by Person Z was dated 8/15/2010. The DOJ (Department of Justice) and IBIS (Caregiver Background Check) reports were dated 8/21/2010. The DOJ report noted Theft-False Representation. According to Wisconsin Circuit Court Access, Person Z was	N 219		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 219	Continued From page 26 released from prison 8/28/2012. Administrator A did not provide a complete background check following Person Z's release in 2012. Administrator A informed Surveyor #07178, on 2/19/2013, that she spoke to someone in Madison and was told Person Z could work at the facility, but could not provide patient care and work with finances. Nothing was received in writing to document this alleged conversation. An "Employee," according to DHS 83.02(22) means "any person who works for a CBRF or for an entity that is affiliated with a CBRF or that is under contract to the CBRF, who is under direct control of the CBRF or corporation affiliated with the CBRF and who receives compensation subject to state and federal withholding taxes." Person Z meets this definition because Person Z works for the Ark Haven facilities, including Ark Haven III, as a full time consultant. The facility permitted Person Z to perform tasks related to "inventory of supplies, food, mail to residents, budgeting and services" as identified on her job description. The facility has in the past six months and currently continues to receives public funding under an active contract with a county Family Care Managed Care Organization. The facility inaccurately disclosed to the Department information related to their acceptance public funding and has hired as a consultant a person who is barred from working for an entity that receives public funding.	N 219		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse	N 220		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 220	Continued From page 27 indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Surveyor: 13203 Based upon record review, the CBRF did not ensure that it obtained documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. As evidenced by in 4 of 4 records reviewed: 1) Surveyor #13203's review of Staff B's employee record, on 2/19/2013, reflected that she had been screened for tuberculosis; however, did not reflect that she had been screened for other clinically apparent communicable disease. 2)Surveyor #13203's review of Staff C's employee record, on 2/19/2013, reflected that she had been screened for tuberculosis; however, did not reflect that she had been screened for other clinically apparent communicable disease. 3)Surveyor #13203's review of Staff D's employee record, on 2/19/2013, reflected that she had been screened for tuberculosis; however, did not reflect	N 220		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 220	Continued From page 28 that she had been screened for other clinically apparent communicable disease. 4)Surveyor #13203's review of Staff E's employee record, on 2/19/2013, reflected that she had been screened for tuberculosis; however, did not reflect that she had been screened for other clinically apparent communicable disease. Surveyors shared the above findings with Administrator A on 2/19/2013. No additional information was provided.	N 220		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Surveyor: 13203 Based upon record review and interview, the facility did not ensure that the administrator and resident care staff received at least 15 hours per calendar year of continuing education, beginning with the first full calendar year of employment that included at a minimum, all of the following: (1) Standard precautions; (2) Client group related	N 277		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 277	Continued From page 29	N 277		

training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid.

As evidenced by in 3 of 3 employee records and the administrator records reviewed by Surveyor #07178 and Surveyor #13203.

1) On 1/30/2013, Surveyor #07178 requested that Administrator A provide her complete employee record including all continuing education to the department for review. Administrator A stated she would copy her entire file including any continuing education and provide copies to the department.

Surveyor #07178's review of Administrator A's record on 1/30/2013 reflected a date of hire of 4/3/2003. Administrator A's record did not reflect that she had received any continuing education in 2011 and/or 2012.

2) Surveyor's review of Staff B's (Caregiver) record, on 2/19/2013, reflected a date of hire of 9/30/2011. The record reflects Staff F had completed the required 15 hours of continuing education; however, did not reflect that she had received the required training on fire safety.

3) Surveyor's review of Staff C's (Caregiver) record, on 2/19/2013, reflected a date of hire as 8/22/2010. The record reflects Staff G had completed the required 15 hours of continuing education; however, did not reflect that she had received the required training on fire safety.

4) Surveyor's review of Staff D's (Caregiver) record, on 2/19/2013, reflected a date of hire as 12/12/2011. The record reflects Staff G had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 277	Continued From page 30 completed the required 15 hours of continuing education; however, did not reflect that she had received the required training on fire safety. Surveyor's review of Staff B, Staff C and Staff D's "Employee Continuing Education Flow sheet" reflected the documents appeared to have been photocopied. Surveyor observed the location of handwritten dates, number of hours attended, topics and a X, indicating if an employee had attended, were identical in appearance and location on all three employee forms in 6 of 6 trainings. Surveyor also observed the same form had been used, indicating the same information, for 3 employees at the adjacent facility Ark Haven for the Elderly 3. Topics staff were allegedly trained in include: -Caregiver Professional Professionalism in a challenging environment -Attachment / Dealing with death of a resident -Chart review -Resident rights -Reporting / Documentation -Medication Mgt / ISP Surveyor's review reflected Staff D had attended "Caregiver Professional Professionalism in a challenging environment," on 11/16/2011; however, Staff D was not hired by the facility until 12/12/2011. Surveyor's review reflects no documentation of who provided any of the continuing education training. Surveyor interviewed Administrator A on 2/19/2013. Administrator A said that employees obtain their continuing education from several different sources including herself. As indicated in Example #1, surveyor's review of Administrator A's record reflects that she had not received any	N 277		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 277	Continued From page 31 continuing education either in 2011 and/or 2012. Surveyors shared insufficient continuing education findings with Administrator A on 2/19/2013. No additional information was provided.	N 277		
N 385	83.35(2) Temporary Service Plan. Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented. This Rule is not met as evidenced by: Surveyor: 07178 Based on record review and staff interview, the facility did not develop a temporary service plan for two of two reviewed resident records, who were recently admitted to the facility. The plan should meet the immediate needs of the resident. Findings include: 1. On 2/20/2013, Surveyor #07178 reviewed the record of Resident #6. Resident #6 was admitted to the Ark Haven For The Elderly II (neighboring facility) on 7/1/2011 with a diagnosis including Schizophrenia, Diabetes Mellitus Type II, and Hypertension. According to the Shift to Shift Reports, Resident #6 was transferred into Ark Haven For The Elderly on 2/11/2013 from Ark Haven II. (Neighboring facility.) A review of the record noted the ISP for Resident	N 385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 385	Continued From page 32 #6 was dated 6/18/2012. The ISP did not identify his immediate needs related to the transfer. The record did not contain an individual service plan for the 2/11/2013 admission to the home. On 2/20/2013, Surveyor #07178 interviewed Administrator A regarding Resident #6's admission to the facility. Administrator A stated that she closed his previous home, Ark Haven For The Elderly II about one week ago so that the facility could be painted and floors repaired. Administrator A stated that this would be a temporary move. Administrator A stated that the ISP in the record was the current one. On 2/26/2013, Surveyor #07178 interviewed Case Manager H. Case Manager H stated that he had never attended any care plan review meeting or individual service plan meeting. On 2/11/2013, Resident #6 moved into the Ark Haven For The Elderly from the neighboring facility, Ark Haven For The Elderly II. Surveyor #07178 asked Case Manager H if Administrator A or any other staff had notified him that Resident #6 was transferred out of his home. Case Manager H stated he was not notified of the move. 2. On 2/19/2013, Surveyor #07178 reviewed the record of Resident #4. Resident #4 was admitted to the facility on 8/17/2012. Resident #4's diagnosis included Severe Dementia, Peripheral Edema and Mild Cellulitis. The record did not contain any temporary individual service plan addressing his immediate needs. Per the record, Resident #4 had needs related to	N 385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 385	Continued From page 33 circulation, diet, dementia and falls. On 2/19/2013, Surveyor #31903, #13203 and #07178 informed Administrator A of the above findings. Administrator A stated that Resident #6 and #4's record was complete. She would check the file for any ISP and fax it to the department by 2/22/2013. As of 2/28/2013, the department received no additional information. Cross Reference: DHS 83.12(4)(c) Reporting and Notification Requirements DHS 83.15(3)(a) Administrator Supervision DHS 83.38(1)(i) Maintain Resident Record	N 385		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Surveyor: 07178 Initially cited on standard licensure visit. Refer to SOD #9KUT11, dated 2/4/2011. Uncorrected on verification visit. Refer to SOD #9DUT12, dated 1/23/2012. Corrected on verification visit. Refer to SOD	N 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 386	Continued From page 34 #9KUT13, dated 6/20/2012. Repeat violation, on this current standard licensure visit. Refer to SOD #IBSU12, dated 2/28/2013. Based on record review, staff interview and interview with case managers, the CBRF did not develop a comprehensive individual service plan for each resident which included all the following: 1. Identify the resident's needs and desired outcomes. 2. Identify the program services, frequency and approaches under DHS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. Findings include: 1. On 2/19/2013, Surveyor #07178 reviewed the record of Resident #2. Resident #2 was admitted to the facility on 7/20/2012 with diagnoses including ETOH Abuse, Seizure Disorder, Paralysis and Spinal Cord Injury. A review of the "Individual Service Plan" for Resident #2 was dated 7/20/2012. Administrator A identified this plan as the "temporary service plan" and that the facility completes a 30 day plan. This ISP (Individual Service Plan) was the only plan in Resident #2's record. Surveyor #07178 asked Administrator A if that was the current ISP for Resident #2. The ISP contained Administrator A signature. Administrator A stated it was. The ISP did not address any history of Alcoholism, current drinking issues, or any behavioral issues. Facility staff had documented in a "Shift to Shift" report that they searched	N 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 386	Continued From page 35 Resident #2's room and found alcohol which was then poured down the toilet. No approaches to address the behavioral issue were identified. Resident #2 had falls at the facility resulting in bruising and a laceration to his head. No documentation or concern related to falls were identified. The ISP did not identify any desired outcomes. The ISP did not contain measurable goals with specific time limits for attainment. The ISP did not identify methods for delivering needed care and who is responsible for delivering the care. The ISP did not contain signatures of Resident #2 nor the case manager. On 2/19/2013, Surveyor #07178 interviewed Resident #2. Resident #2 stated he does not receive showers at the facility. He indicated that he washes himself without showering. He stated he uses a bed bar to assist him in getting into his bed and out of the bed. On 2/26/2013, Surveyor #07178 interviewed Case Manager J. Case Manager J stated she has never been to a care plan or individual service plan meeting on Resident #2 at the facility. Case Manager J has asked Administrator A on two different occasions to meet to discuss Resident #2's needs; however, Administrator A canceled both the meetings. On 2/26/2013, Surveyor #07178 interviewed RN Case Manager I regarding Resident #2's care. RN Case Manager I stated that on 1/3/2013, she observed Resident #2's skin. RN Case Manager I stated that on the right thigh was a large bruise the size of 2 1/2 dollar size in circumference. His	N 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 386	Continued From page 36	N 386		

right buttock contained a similar sized bruised. Dried fecal matter was observed on his buttock area, which appeared to have been on his skin a long time. RN Case Manager I stated to Surveyor #07178 that she had asked staff to offer Resident #2 assistance with showering and staff told her he refuses.

Following the 1/3/2013 observation of the dried feces, RN Case Manager I stated that she spoke to Caregiver B regarding Resident #2's showering. Caregiver B stated that she was able to assist Resident #2 with a shower. She used a very kind and gentle approach and he was cooperative.

RN Case Manager I stated to Surveyor #07178 that Resident #2 requires a grab bar in his bathroom to assist with toileting. RN Case Manager I stated she had requested that Administrator A provide the bar. RN Case Manager I indicated that she had requested this for a long time and he still does not have the device.

Resident #2's needs related to showering, personal care, hygiene, transfer bar to get in and out of bed, behaviors were not addressed by the CBRF. The CBRF did not identify the program services they would provide, did not establish measurable goals with specific time limits for attainment and did not specify methods for delivering needed care and who is responsible for delivering the care to Resident #2.

2. On 2/20/2013, Surveyor #07178 reviewed the record of Resident #6. Resident #6 was admitted to the Ark Haven For The Elderly II (neighboring facility) on 7/1/2011 with a diagnosis including Schizophrenia, Diabetes Mellitus Type II, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 386	Continued From page 37 Hypertension. According to the Shift to Shift Reports, Resident #6 was transferred into Ark Haven For The Elderly on 2/11/2013 from Ark Haven II. (Neighboring facility.) A review of the record noted the ISP for Resident #6 was dated 6/18/2012. The ISP did not identify his immediate needs related to the transfer. The record did not contain an individual service plan for the 2/11/2013 admission to the home. On 2/20/2013, Surveyor #07178 interviewed Administrator A regarding Resident #6's admission to the facility. Administrator A stated that she closed his previous home, Ark Haven For The Elderly II about one week ago so that the facility could be painted and floors repaired. Administrator A stated that this would be a temporary move. Administrator A stated that the ISP in the record was the current one. On 2/26/2013, Surveyor #07178 interviewed Case Manager H. Case Manager H stated that he had never attended any care plan review meeting or individual service plan meeting. On 2/11/2013, Resident #6 moved into the Ark Haven For The Elderly from the neighboring facility, Ark Haven For The Elderly II. Surveyor #07178 asked Case Manager H if Administrator A or any other staff had notified him that Resident #6 was transferred out of his home. Case Manager H stated he was not notified of the move.	N 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 386	Continued From page 38	N 386		

Surveyor: 13203
Surveyor #13203's review of Resident #5's record, on 2/19/2013, reflected an admission date of 7/26/2012. Resident #5 was admitted into the facility after being hospitalized for alcohol detoxification. Resident #5 was admitted with a history of alcohol abuse and related withdrawal seizures, diabetes and arthritis.

An admission physical completed on 8/8/2012 reflects, not limited to, the following needs: Resident has multiple medical conditions driven by alcohol abuse, including convulsion and alcoholic dementia. Resident was diagnosed with a abdominal aortic aneurysm, predisposed by cigarette smoking. Resident has diabetes mellitus, tremors and is at high risk for falls.

Surveyor's review reflected an initial individualized service plan (ISP) dated at the time of admission as 7/26/2012. The ISP reflects staff will test residents blood sugars and know his whereabouts at all times. The ISP does not address resident's alcohol abuse and related complications of convulsions, seizures and dementia. The plan does not address resident's cigarette smoking and related complication of an abdominal aortic aneurysm. The plan does not reflect resident is a high risk for falls.

On 2/19/2013, Surveyor #07178 observed Resident #7 with a deep red-purple bruise on the left side of his face, the left corner of his mouth/lip and left facial cheek. Surveyor #07178 asked Caregiver B how Resident #7 sustained the bruising. Caregiver B stated Resident #5 had hit him in the mouth. Caregiver B stated that he had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 386	Continued From page 39 just pushed Resident #8 to the floor and she would be completing an incident report on that incident as well. A review of the "Shift to Shift" report dated 2/17/2013 noted the following: "(Resident #5) had a fight and hit (Resident #7) in the mouth." The ISP did not address Resident #5's behaviors which included physical aggression. Surveyor's review of the record reflected no comprehensive individual service plan was developed within 30 days after admission. The facility did not ensure that a comprehensive individual service plan was developed that identified Resident #5's needs and desired outcomes related to his substance abuse, health care needs and/or behavioral needs. The facility did not ensure that a ISP was developed that identified the program services, frequency and approaches under s. DHS 83.38(1) the CBRF would provide to Resident #5 to meet his needs. The facility did not ensure that it developed an ISP that establish measurable goals with specific time limits for attainment for Resident #5. The facility did not ensure that an ISP was developed that specified methods for delivering needed care to Resident #5 and who was responsible for delivering the care.	N 386		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If	N 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 387	Continued From page 40 a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Surveyor: 07178 Initially cited on verification visit. Refer to SOD #9DUT12, dated 1/23/2012. Uncorrected on verification visit. Refer to SOD #9KUT13, dated 6/20/2012. Remains uncorrected on standard licensure and verification visit. Refer to SOD #IBSU12, dated 2/28/2013. Based on record review and staff interview, the CBRF did not involve the resident and the resident's legal representative, as appropriate, for 2 out of 2 residents in developing the (ISP) individual service plan, and the resident or the resident's legal representative was not afforded the opportunity to sign the plan, acknowledging their involvement in, understanding of and agreement with the plan. The residents' case managers were not invited to participate in the development of the service plan. Findings include: 1. On 2/19/2013, Surveyor #07178 reviewed the record of Resident #2. Surveyor #07178 reviewed the record of Resident #2 on 2/19/2013. Resident #2 was admitted to the facility on 7/20/2012 with diagnoses including ETOH Abuse, Seizure Disorder, Paralysis and Spinal Cord	N 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 387	Continued From page 41 Injury. A review of the "Individual Service Plan" for Resident #2 was dated 7/20/2012. Administrator A stated this plan was the "Temporary Service Plan" until the 30 day evaluation was completed. This ISP (Individual Service Plan) was the only plan in Resident #2's record. Surveyor #07178 asked Administrator A if that was the current ISP for Resident #2. She verified that it was. The ISP did not reflect signatures of either the resident and/or the case manager indicating their involvement in, understanding of and agreement with the plan. On 2/26/2013, Surveyor #07178 interviewed Case Manager J. Case Manager J stated she has never been to a care plan or individual service plan meeting on Resident #2 at the facility. Case Manager J has asked Administrator A on two different occasions to meet to discuss Resident #2's needs however, Administrator A canceled both the meetings. The facility did not ensure that the resident's case manager was invited to participate in the development of the service plan. 2. Surveyor #07178 reviewed the record of Resident #1 on 2/19/2013. Resident #1 was admitted to the facility on 2/26/2011 with diagnoses including Arthritis, Hearing Deficit, Dementia and Diabetes Mellitus. The record contained a ISP dated 6/18/2012. The ISP contained no signatures of the participants. On 2/27/2013, Surveyor #07178 interviewed	N 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 387	Continued From page 42 Case Manager L regarding Resident #1. Surveyor #07178 asked Case Manager L if she was invited to attend a care conference or individual service plan meeting for Resident #1. Case Manager L stated she was never invited to a care plan or service plan meeting for Resident #1. Per Plan of Correction, received by the Department on 8/2/2012, signed by Administrator A. Administrator A disclosed that the facility would correct the violation issued in SOD #9KUT13 dated 6/20/2012 by 10/1/2012. As of 2/28/2013, the violation was not corrected.	N 387		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Surveyor: 07178 Based on record review and staff interview, the CBRF did not complete a Individual Service Plan (ISP) review annually or when there was a change in a resident's needs, physical or mental condition. All reviews of the ISP shall include input from the resident or legal representative,	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 389	Continued From page 43 case manager, resident care staff, and other service providers as appropriate. The participants shall sign the ISP acknowledging their involvement and agreement. Findings include: On 2/19/2013, Surveyor #07178 reviewed the record of Resident #2. Resident #2 was admitted to the facility on 7/20/2012 with diagnoses including ETOH Abuse, Seizure Disorder, Paralysis and Spinal Cord Injury. A review of the "Individual Service Plan" for Resident #2 was dated 7/20/2012. Administrator A stated this plan was the "Temporary Service Plan" until the 30 day evaluation was completed. This ISP (Individual Service Plan) was the only plan in Resident #2's record. Surveyor #07178 asked Administrator A if that was the current ISP for Resident #2. Administrator A stated it was. The ISP did not address any history of Alcoholism, current drinking issues, or any behavioral issues. In the section under "Cognitive" the following were identified: "Behavior-Staff will redirect (Resident #2) as needed with any Behavior Concerns." "Wandering-Staff will know (Resident #5-peer of Resident #2) whereabouts at all time." "Decision making-(Resident #2) is capable of making his own decision." No concern related to falls was identified. The ISP did not reflect that it was reviewed and revised after a change in Resident #2's physical condition required hospitalizations on 9/4/2012, 9/15/2012, 12/21/2012, 12/30/2012. The ISP contained Administrator A's signature;	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 389	Continued From page 44 however, did not contain signatures of Resident #2 nor the case manager acknowledging their involvement in, understanding of and agreement with the individual service plan. On 2/26/2013, Surveyor #07178 interviewed Case Manager J. Case Manager J stated she has never been to a care plan or individual service plan meeting on Resident #2 at the facility. Case Manager J has asked Administrator A on two different occasions to meet to discuss Resident #2's needs however, Administrator A canceled both the meetings.	N 389		
N 393	83.35(5)(a) Initial evaluation of evacuation limitations. Initial evaluation. The CBRF shall evaluate each resident within 3 days of the resident ' s admission to determine whether the resident is able to evacuate the CBRF within 2 minutes in an unsprinklered CBRF and 4 minutes in a sprinklered CBRF without any help or verbal or physical prompting, and what type of limitations that resident may have that prevent the resident from evacuating the CBRF within the applicable period of time. A form provided by the department shall be used for the evaluation. The resident ' s evaluation shall be retained in the resident ' s record. This Rule is not met as evidenced by: Surveyor: 07178 Based on record review and staff interview, the CBRF did not evaluate one out of one residents reviewed, within 3 days of the resident's admission to determine whether the resident is able to evacuate the CBRF within 2 minutes, and	N 393		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 393	Continued From page 45 to determine the type of limitations that resident may have that prevent the resident from evacuating the CBRF within the applicable period of time. The CBRF is to use the form provided by the Department for the evaluation and the evaluation shall be retained in the resident's record. Findings include: On 2/20/2013, Surveyor #07178 reviewed the record of Resident #6. Resident #6 was transferred to Ark Haven For The Elderly on 2/11/2013. The record did not contain an evacuation assessment to determine whether the resident is able to evacuate the CBRF within 2 minutes, and to determine the type of limitations that resident may have that prevent the resident from evacuating the CBRF within the applicable period of time. The completed Department evaluation form was not included in the resident's record. On 2/20/2013, Administrator A stated that Resident #6 had moved into the facility about one week ago and that they are currently painting his previous home. Administrator A stated she believed this move was temporary. No reason was provided as to why the form had not been completed and included in his record. Cross Reference: DHS 83.42(1) Maintain Resident Record	N 393		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a	N 407		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 407	Continued From page 46 pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential benefits and side effects of the medication. This Rule is not met as evidenced by: Surveyor: 07178 Initially cited on standard licensure visit. Refer to SOD #9KUT11, dated 2/4/2011. Uncorrected on verification visit. Refer to SOD #9DUT12, dated 1/23/2012. Corrected on verification visit. Refer to SOD #9KUT13, dated 6/20/2012. Repeat violation, on this current standard licensure visit. Refer to SOD #IBSU12, dated 2/28/2013. Based on record review and staff interview, the CBRF did not ensure that 3 out of 3 residents reviewed were reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident's record. Findings include: 1. On 2/19/2013, Surveyor #31903 reviewed the record of Resident #2. Resident #2 was admitted to the facility on 7/20/2012. Resident #2 had physician order for Lorazepam 2 mg one tablet three times per day; Paroxetine HCL 10 mg per day.	N 407		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 407	Continued From page 47 The record did not contain any psychotropic medication review. On 2/19/2013, Administrator A informed Surveyors #13203 and #07178 that her Nurse Consultant F visits the home one time per week or as needed but had not been to the facility for the past 3 weeks although remains on her payroll. Administrator A stated that Nurse Consultant F completes the medication reviews but that she did not have the reviews at the facility. Administrator A stated she had not recently spoken to Nurse Consultant F regarding the reviews, but that since he had not been to the facility in the last 3 weeks, she hired a medical director to complete the reviews in the future. On 2/19/2013, Surveyor #07178 asked Administrator A for the psychotropic medication reviews from 7/2012. Administrator A stated she had the reviews in a different file and would fax the review to the Department by 2/22/2013. As of 2/285//2013, the department did not receive any other reviews from 7/2012 reflecting that the review was done on a quarterly basis. No reason was provided as to why previous quarterly reviews were not provided to the department. No reason was provided as to why the reviews/assessments were not included in Resident #2's record. 2. On 2/19/2013, Surveyor #07178 reviewed the Record of Resident #4. Resident #4 was admitted to the facility on 8/17/2012. Resident #4's diagnosis included Severe Dementia, Peripheral Edema and Mild Cellulitis. Resident #4 had a physician order for Donepezil HCL 5 mg one tablet per day.	N 407		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 407	Continued From page 48 The record contained no psychotropic medication review. On 2/19/2013, Administrator A informed Surveyors #13203 and #07178 that her Nurse Consultant F visits the home one time per week or as needed but had not been to the facility for the past 3 weeks although remains on her pay roll. Administrator A stated that Nurse Consultant F completes the medication reviews but that she did not have the reviews at the facility. Administrator A stated she had not recently spoken to Nurse Consultant F regarding the reviews but that since he had not been to the facility in the last 3 weeks, she hired a medical director to complete the reviews in the future. On 2/19/2013, Surveyor #07178 asked Administrator A for the psychotropic medication reviews from 8/2012. Administrator A stated she had the reviews in a different file and would fax the review to the department by 2/22/2013. As of 2/25//2013, the department did not receive any other reviews from 8/2012 reflecting that the review was initially. No reason was provided as to why previous quarterly reviews were not provided to the department. No reason was provided as to why the reviews/assessments were not included in Resident #4's record. 3. Surveyor #13203's review of Resident #3's record, on 2/19/2013, reflects a date of admission of 9/1/2006. Surveyor's review reflects Resident #3 has been receiving the psychotropic medications of Olanzapine, Haloperidol and Divalproex Sodium since, not limited to, 11/11/2011. The record contained no psychotropic medication	N 407		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 407	Continued From page 49 reviews. On 2/19/2013, Administrator A informed Surveyors #13203 and #07178 that her Nurse Consultant F visits the home one time per week or as needed but had not been to the facility for the past 3 weeks although remains on her pay roll. Administrator A stated that Nurse Consultant F completes the medication reviews but that she did not have the reviews at the facility. Administrator A stated she had not recently spoken to Nurse Consultant F regarding the reviews but that since he had not been to the facility in the last 3 weeks, she hired a medical director to complete the reviews in the future. The facility did not ensure that residents who receive psychotropic medication were evaluated by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident's record. Cross Reference: DHS 83.42(1) Maintain Resident Record	N 407		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not	N 408		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 408	Continued From page 50 limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Surveyor: 13203 Initially cited on standard licensure visit. Refer to SOD #9KUT12, dated 1/23/2012. Corrected on verification visit. Refer to SOD #9KUT13, dated 6/20/2012. Repeat violation, on this current standard licensure visit. Refer to SOD #IBSU12, dated 2/28/2013. Based upon record review the facility did not ensure that when a psychotropic medication was prescribed on an as needed basis for Resident #5 that the facility did all of the following: 1. Developed and individual service plan that included the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. Documented in the resident's record the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. Surveyor's review of Resident #5's Medication Administration Record (MAR) reflects Resident	N 408		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 408	Continued From page 51 #5 receives Haloperidol and Diazepam (Valium) on as needed basis. Surveyor #13203's review of Resident #5's, as needed, (MAR), for 11/27/2012 thru 2/17/2013 reflects Resident #5 received Haloperidol 19 times and Diazepam 14 times. Surveyor's review of Resident #5's record reflects the facility did not ensure the development of an individual service plan which included the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. Surveyor's review of the Haloperidol reflects that it was ordered for and given for agitation. The record does not reflect documentation of Resident #5 being monitored for side effects and/or for inappropriate use. Surveyor's review reflects that the Diazepam was given on 11/27/2012 and 12/1/2012 with no documented rationale for use and/or description of behaviors. The MAR reflects the Diazepam was given on 10 additional occasions because the resident requested it; however, does not document a description of the behaviors observed if any. The record does not reflect documentation that Resident #5 was being monitored for side effects and/or for inappropriate use. Cross Reference: DHS 83.35(3)(a) Comprehensive Individualized Service Plan	N 408		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers,	N 416		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 416	Continued From page 52 stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Surveyor: 13203 Initially cited on standard licensure visit. Refer to SOD #9KUT11, dated 2/4/2011. Uncorrected on verification visit. Refer to SOD #9DUT12, dated 1/23/2012. Corrected on verification visit. Refer to SOD #9KUT13, dated 6/20/2012. Repeat violation, on this current standard licensure visit. Refer to SOD #IBSU12, dated 2/28/2013. Based upon record review and interview the facility did not ensure that injectable medications were administered by a registered nurse, licensed nurse and/or delegated, by a registered nurse, to non-licensed employees pursuant to s. N 6.03(3). Surveyor #13203's review of Resident #7's medication administration records, on 2/19/2013, reflected the following: Resident #7 currently has physician orders for two injectable medications. Resident #7 is to receive a daily subcutaneous injection of 8 units of Humulin N Insulin in the morning and 6 units in the evening for diabetes. Resident #7 is to receive an intramuscular injection of Cyanocobalamin (Vitamin B 12) once a month, on the 10th of the month. On 2/19/2013, Administrator A informed Surveyors #13203 and #07178 that she employs a Nurse Consultant F. Administrator A said the	N 416		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 416	Continued From page 53 nurse consultant is not in the facility daily; however, normally visits the home one time per week or as needed. Administrator A said that the nurse consultant had not been to the facility for the past 3 weeks although remains on her payroll. Surveyor #07178 and Regional Field Operations Supervisor AA attempted to contact Nurse Consultant F, to verify his employment status at the facility, on 2/28/2013; however, Person F has not returned the calls. Surveyor interviewed Staff B (Caregiver) who said she uses an insulin pen to give Resident #7 his insulin. Surveyor's review of Staff B's employee file does not reflect documentation that she has been trained on giving injections and/or that this act has been delegated to her by Nurse Consultant F. Surveyor's review of Staff C and Staff D's employee records reflected no documentation that they have been trained on giving injections and/or that this act has been delegated to them by Registered Nurse F.	N 416		
{N 431}	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. HFS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 431}	Continued From page 54 an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Surveyor: 07178 Initially cited on standard licensure visit. Refer to SOD #9KUT11, dated 2/4/2011. Uncorrected on verification visit. Refer to SOD #9DUT12, dated 1/23/2012. Corrected on verification visit. Refer to SOD #9KUT13, dated 6/20/2012. Recited on complaint investigation. Refer to SOD #IBSU11, dated 10/4/2012. Uncorrected on current standard licensure visit. Refer to SOD #IBSU12, dated 2/28/2013. Based on interview, record review and hospital record review the CBRF did not provide or arrange services to meet the needs of the residents in the area of health monitoring. The CBRF did not document communication with the resident's physician and did not record any changes in the residents' health in the resident's record for 3 out of 5 sampled residents. Resident #4 required health monitoring when Resident #4 was initially admitted to the facility	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 431}	Continued From page 55 and shortly after admission, when his foot became gangrene and needed to be amputated. Resident #4 died shortly after the amputation. The facility did not record any changes in Resident #4's record related to his physical health needs, did not ensure Vascular specialist follow up as ordered by his physician and did not provide appropriate care to meet his needs. Resident #1 was to attend wound clinic weekly. The CBRF did not arrange services adequate to meet the needs of Resident #1 who received services from a local wound treatment center. The CBRF did not maintain documentation of the weekly wound care treatment visits. The CBRF did not ensure that the record contained documentation that Resident #3 attended scheduled appointments with a Ophthalmologist, a Urologist, a Rheumatologist, an ENT and a Neurologist. The record reflects no documentation that the facility communicated with the resident's physician and other health care providers on the status of Resident #3 health or mental health regarding these appointments. Findings include: 1. On 2/19/2013, Surveyor #07178 reviewed Resident #1's record. Resident #1 was admitted to the facility on 2/26/2011. Resident #1's diagnosis included Arthritis, Pancreatitis, Diabetes Mellitus, Glaucoma, Hyperlipedmia, Hypertension and Renal Failure. Resident #1 had physician orders for wound treatment for his lower extremities which included compression wraps and skin grafts. The wound treatments were completed at a local wound care clinic.	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 431}	Continued From page 56 Resident #1 was seen by the wound clinic on 1/28/2013 for treatment. The clinic completed a physician visit form indicating that Resident #1 is to return to the clinic in one week for follow-up. A review of wound clinic progress notes reflected the date of the appointments with the appointment times which were scheduled by the clinic were 2/4/2013 at 10 am and 2/11/2013 at 10 am. Resident #1's record did not contain follow up progress notes related to these visits. On 2/19/2013, Surveyor #07178 interviewed Administrator A regarding the appointments. Administrator A stated she believed the reports were in the record. Administrator A looked through the record but was not able to locate the visit forms. Administrator A stated she would fax the reports to the department by 2/22/2013. As of 2/28/2013, the Department did not receive the reports. On 2/27/2013, Surveyor #07178 interviewed Case Manager L regarding the clinic progress notes. Case Manager L stated that she reviewed Resident #1's record at the facility a few days ago and was not able to locate the reports either. 2. Surveyor #07178 reviewed the record of Resident #4 who was admitted to the facility on 8/17/2012 with a diagnosis including Severe Dementia, Peripheral Edema and Mild Cellulitis. According to the pre-admission assessment for Resident #4, dated 8/1/2012, completed by Administrator A, Resident #4's skin was dry and intact. He ambulated independently. No behavioral concerns noted. No leg or ankle edema or swelling was noted. A fall assessment	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 431}	Continued From page 57 was dated 8/1/2012. The assessment noted low risk for falls. According to the "Interdisciplinary Discharge Instructions/Summary" dated 8/17/2012 from Franciscan Villa (the facility Resident #4 resided prior to Ark Haven) Resident #4 needed assistance of one for activities of daily living and toileting. Resident #4 needed one assist for transfers and mobility with wheeled walker. "Wound Care, Treatments, Therapy" noted "none" for procedures. The updated History and Physical completed the physician dated 8/14/2012 noted "Peripheral edema, likely hymphedema acute on chronic and Mild cellulitis lower legs." "The last several days increased falls." On 9/4/2012, Physician G documented the following: "Severe Peripheral Vascular Disease, Black right toes." "Toes 1, 2 severe PVD" (peripheral vascular disease). "Referral to vascular surgery." This physician note was signed by Physician G and dated 9/4/2012. Resident #4's record did not contain any Vascular follow up. Resident #4's record did not contain a temporary individual service plan which identified any medical needs or treatment needs related to the feet. Resident #4's record did not contain any admission assessment addressing any immediate medical needs. The record did not contain any information related to any falls at the facility and any treatment needs	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 431}	Continued From page 58 for Resident #4. The record contained no documentation regarding his skin condition and treatment of the cellulitis and edema. On 10/3/2012, the Department received a complaint regarding the care of Resident #4. The complainant indicated that on 9/13/2012, Resident #4 was admitted to the hospital due to a fall at Ark Haven for the Elderly. Resident #4 sustained a 9cm laceration to his right shin. The hospital noted that the resident sustained the laceration when he fell out of his bed as witnessed by is roommate. While at the hospital, the right leg and foot were assessed and found to be "discoloration purplish to left ankle to foot region." The hospital completed a vascular evaluation and as the foot was noted to be gangrene, it was amputated. On 2/22/2013, Surveyor #07178 interviewed Administrator A regarding Resident #4. Administrator A stated he did not fall while at the facility and on 9/13/2012. When asked if he sustained a laceration to the right shin, Administrator A stated he arrived on 8/17/2012 with the laceration. A review of hospital record noted the following: Emergency Department: "Cause of injury: fall from bed 9/13/2012." "Diagnosis: Atrial Fibrillation, Arterial Insufficiency, Laceration of Leg." The Emergency Report noted "Cold mottled left foot. Assisted living facility unsure how long foot this way. No pulses, no pulses via Doppler." History and Physical: "Fell out of bed today, has severely diminished arterial flow to left foot. Behavior at baseline per assisted living facility.	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 431}	Continued From page 59 They are unable to confirm chronicity of left foot ischemia." "Discoloration purplish to left ankle to foot region." Wound repair: "The 9cm long linear wound ...." The note further read: "Patient evaluated by vascular. Patient will need amputation. No evidence of sepsis. Daughter stated in mid of August no problems with feet." Final Diagnosis: Gangrene Embolism and Thrombosis of arteries of lower extremity Rhabdomyolysis Systemic Inflammatory response syndrome unspecified." On 9/17/2012, Resident #4 left leg, above the knee was amputated. On 9/21/2012, he was discharged from the hospital and admitted to subacute facility where he died on 9/28/2012. The CBRF did not monitor and provide care as required to Resident #4. The CBRF did not monitor his medical needs related to his history of Edema, Cellulitis and Dementia. The CBRF did not arrange for Vascular follow up from the 9/4/2012 physician visit. The CBRF did not document his needs related to falls, overall skin condition, and treatment needs. The CBRF did not record any changes in his condition in the record and arrange for appropriate services. Surveyor: 13203 3. Surveyor #13203 review of Resident #3's record on 2/19/2013 reflected Resident #3 was admitted to the facility on 9/1/2006. Resident #3's admission diagnosis included Dementia with disturbed behavior, Mental Retardation, Traumatic Brain Injury, History of Schizophrenia, Hypothyroidism and Seizure Disorder.	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 431}	Continued From page 60 -Surveyor's review of Statement of Deficiency (SOD) IBSV11, dated 10/4/2012 reflects the following: Resident #3 was seen by his physician, Physician D on 4/18/2012 for a complete medical examination. At that appointment, Physician D ordered follow up with the ENT physician, Ophthalmologist and a Urologist. Resident #3 was hospitalized on 7/27/2012. The physician ordered follow-up with a Neurologist in 2-4 weeks. Administrator A reported that Resident #3 was seen by a Gastroenterologist on 8/15/2012 but they did not have report as the resident did not have any problems. Administrator A stated that Resident #3 was scheduled to see an Ophthalmologist on 10/20/2012; a Urologist on 12/18/2012; a Rheumatologist on 11/1/2012; the ENT on 10/5/2012 and a Neurologist on 10/17/2012. No information was provided as to why the appointments were not scheduled in 4/2012 when ordered by the physician. As of 10/4/2012, Resident #3 had not been seen by the Ophthalmologist, ENT, Neurologist and Urologist when ordered by the physician in 4/2012. -Surveyor's review of the plan of correction for SOD IBSV11 reflects that Administrator A would be in compliance with this violation effective 2/15/2013. Surveyor #13203's review of Resident #3's record on 2/19/2013 reflects no documentation that	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 431}	Continued From page 61 Resident #3 attended the appointments with the Ophthalmologist on 10/20/2012; a Urologist on 12/18/2012; a Rheumatologist on 11/1/2012; the ENT on 10/5/2012 and a Neurologist on 10/17/2012. The record reflects no documentation that the facility communicated with the resident's physician and other health care providers on the status of Resident #3 health or mental health regarding these appointments. On 2/27/2013 Surveyor #13203 interviewed Person M (Family Care Registered Nurse). Person M said she had been to the facility, during the week of 2/17/2013, to see Resident #3. Person M said she was not able to confirm if Resident #3 had attended the required appointments as there was no documentation in the record. Cross Reference: DHS 83.12(4)(c) Reporting Serious Injury requiring hospitalization DHS 83.35(2) Temporary Individual Service Plan DHS 83.42(1) Maintain Resident Record	{N 431}		
N 433	83.38(1)(i) Behavior management. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. HFS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Surveyor: 07178	N 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 433	Continued From page 62 Based on resident interview, staff interview and record review, the CBRF did not provide services to manage Resident #2's behaviors that may be harmful to himself or others. Resident #2 had a history of alcohol abuse, he continued to drink alcohol at the facility, and would become angry when staff intervened. Staff members would search his room without his permission and empty his bottles of alcohol. Findings include: 1. Surveyor #07178 reviewed the record of Resident #2 on 2/19/2013. Resident #2 was admitted to the facility on 7/20/2012 with diagnoses including ETOH Abuse, Seizure Disorder, Paralysis and Spinal Cord Injury. The record contained documentation from a hospitalization on 9/5/2012. He arrived at the Emergency Room and was intoxicated. Had fallen from his wheelchair. On 12/21/2012, Resident #2 was taken to Froedert Hospital in which he arrived intoxicated and stated he had a fight at his group home. It was noted that Resident #2 reported that staff at the group home had assaulted him. He indicated that he did not want to return to the facility. He stated that the caregiver had drove his wheelchair around the corner, grabbed the patient, pushed him into the wall and banged his head into the wall several times. Froedert examined Resident #2 and the record contained further documentation from Milwaukee County Behavioral Health Team arrived at Froedert to assess Resident #2. A referral to Elder Abuse was made.	N 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 433	Continued From page 63 12/30/2012 at the Froedert Emergency Department noting Resident #2 was diagnosed with Intoxication. Resident #2 stated he "had facial pain after he had fallen out of bed 4-5 times." According to the hospital "History and Physical dated 12/30/2012, the emergency room nurse had contacted a caregiver at Ark Haven and it was reported by the caregiver that Resident #2 had locked himself in his room, when he came out of his room he wanted to pick a fight with another resident. She rolled him back to his room and fell out of his wheelchair into his bed. Another staff came over and put him in bed. Nurse says that he fell out of the bed 4-5 times after that, had to be put back into bed after being found on floor. They are unsure if he hit his head." Resident #2 reported to the emergency room that "he was hit repeatedly in head." "Staff reports falls. Patient has a bump above the left eye. A review of the "Individual Service Plan" for Resident #2 was dated 7/20/2012. This ISP (Individual Service Plan) was the only plan in Resident #2's record. Surveyor #07178 asked Administrator A if that was the current ISP for Resident #2. The ISP contained Administrator A signature. Administrator A stated it was. The ISP did not address any history of Alcoholism, current drinking issues, or any behavioral issues. In the section under "Cognitive" "Behavior-Staff will redirect (Resident #2) as needed with any Behavior Concerns." "Wandering-Staff will know (Resident #5-peer of Resident #2) whereabouts at all time." "Decision making-(Resident #2) is capable of making his own decision." No concern related to falls was identified. A review of the "Shift to Shift Report" (located in a	N 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 433	Continued From page 64 separate binder from Resident #2's record) noted the following: 1/10/2013-2nd shift 3-1 "(Resident #2) came out at 10:45pm-slid out of his wheelchair. Got him up with assisted from 3rd shift. Able to tell me he was drinking alcohol but could not find it." 1/23/2013-2nd shift 3-1 "(Resident #5) brought another residents beer and alcohol. Was drinking a can of 211 (Beer containing a high alcohol content). (Resident #2) went to his room with (Resident #5)...refused his supper. (Resident #2) Medication held due to being intoxicated." 1/24/2013-1st shift 7 am-PM "Searched (Resident #2) room for alcohol, no alcohol found. But found food, cleaning supplies and personal items inside of (Resident #2's) refrigerator/freezer." "(Resident #2) was intoxicated on my shift this pm and PM medications was held. He had his room door barricaded with him sitting in his wheelchair and another blocking him. He refused to let me in, so I pushed against the door until I had room to get into his room. As I entered into his room, there were a bottle of MD 20/20 Orange and a can of 211 (16 fluid ounces.) I called administrator upon me standing next to him. He was upset, but....he can't have alcohol. So I poured the whole bottle of MD 20/20 and the can of 211 beer out into the toilet. (Resident #2) stated 'I don't like you.' I said 'ok, that's fine.' I walked away." Resident #2 had a history of alcoholism, the facility did not address his needs related to current drinking resulting in behavioral health intervention, hospitalization, repeated intoxication	N 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 433	Continued From page 65 at the facility, peer relationship related to purchasing the alcohol. Allegations of abuse by staff at the facility was not addressed nor investigated. The facility did not develop an Individualized Service Plan addressing his behavioral and medical needs. The facility did not develop approaches to address his behaviors. As of 2/28/2013, the Department did not receive any additional information from Administrator A.	N 433		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Surveyor: 13203 Based upon observation and interview the facility did not ensure that the food supply was stored under sanitary conditions. As evidenced by: Surveyor #13203's inventory of the facility food supply, in the facility kitchen, reflected no supply of sugar to be available. Surveyor interviewed Staff B (Caregiver) regarding the surveyor's	N 452		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 452	Continued From page 66 observation. Staff B stated the flour and sugar are stored in Resident #1's room. Surveyor observed Resident #1's room contained a kitchenette. Surveyor observed the kitchenette area being used to store linens and one cabinet being used to store flour, sugar and ramen noodles. Both the sugar and flour packages were observed to have been opened and not re-sealed or re-packaged exposing the sugar and flour to possible contamination.	N 452		
N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved	N 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 454	Continued From page 67 resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Surveyor: 07178 Initially cited on standard licensure visit. Refer to	N 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 454	Continued From page 68 SOD #9KUT12, dated 1/23/2012. Corrected on verification visit. Refer to SOD #9KUT13, dated 6/20/2012. Repeat violation, on this current standard licensure visit. Refer to SOD #IBSU12, dated 2/28/2013. Based on record review and staff interview, the facility did not maintain a record for each resident at the CBRF which included: documentation of health examinations, documentation of significant incidents and illnesses, individual service plans, documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; and documentation of psychotropic medication for 4 out of 4 resident records reviewed. Findings include: 1. On 2/19/2013, Surveyor #07178 reviewed the record of Resident #1. Resident #1 was admitted to the facility on 2/26/2011 with a diagnosis including Arthritis, Dementia and Diabetes. Resident #1 goes to a wound clinic on a weekly basis for wound care treatment. The record did not contain treatment consultation progress notes for 2/4/2013 and 2/11/2013. The record did not contain any progress notes related to general care and needs. Surveyor #07178 interviewed Administrator A regarding the notes. Administrator A stated she escorts him to the clinic and thought the notes were in the record. Administrator A stated she did have some filing to do and would try to locate the records. Administrator A stated she would fax the information to the Department by 2/22/2013. As of 2/28/2013, the Department did not receive any	N 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 454	Continued From page 69 notes related to the treatments at the wound clinic. 2. Resident #4's record was reviewed by Surveyor #07178. Resident #4 was admitted to the facility on 8/17/2012 with a diagnosis including Severe Dementia, Peripheral Edema and Mild Cellulitis. Resident #4's record did not contain an Individual Service Plan (temporary) which is to identify immediate needs of Resident #4. Resident #4 has a physician order for Donepezil HCL 5mg per day; Paroxetine HCL 20mg per day and Divalproex Sodium EC 125mg one tablet twice per day. The record did not a psychotropic medication review. The record did not contain documentation as to the condition of his skin following admission to the home on 8/17/2012. A physician progress noted dated 9/4/2012 indicated Resident #4's toes had "severe PVD" and a referral to Vascular surgery was ordered. The record contain no documentation of the referral being made. The record contained no documentation of the facility monitoring or assessing his feet. On 9/13/2012, Resident #4 had fallen out of this bed as witnessed by his roommate. The record contained no indication of the fall. Resident #4 was sent to the Emergency Room for sutures to the right shin. At the Emergency Room evaluation, the hospital learned that his left foot to ankle was deep purple and a above the knee amputation was completed. The record contained no documentation related to the fall and the change in his skin condition of the feet.	N 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 454	Continued From page 70 3. Resident #6's record was reviewed, by Surveyor #07178, on 2/19/2013. Resident #6 was admitted to the facility, Ark Haven for the Elderly II, on 7/1/2011 with a diagnosis including Schizophrenia, Hypertension and Diabetes. Resident #6's record did not contain a signed Individual Service Plan as reviewed by Resident #6 and the case managers. On 2/11/2013 Resident #6 was transferred to Ark Haven For The Elderly from Ark Haven For The Elderly II (neighboring facility.) The record did not contain an evacuation assessment, a signed admission agreement, and/or a temporary individual service plan. The record did not contain any documentation or progress notes related to care and treatment while at the facility. 4. Surveyor #07178 reviewed Resident #2's record. Resident #2 was admitted to the facility on 7/20/2012 with a diagnosis including Seizure Disorder, Hypertension, Cerebral Vascular Accident, ETOH Abuse and Paralysis. Resident #2's physician ordered Divalproex ER 250mg one tablet twice per day; Divalproex ER 250mg one tablet three times per day; Lorazepam 2mg one tablet three times per day; and Paroxetine HCL 10mg one per day. The record contained no quarterly psychotropic medication reviews. Resident #2 alleged staff abuse on 12/21/2012 and 12/30/2012. The record contained no documentation related to the allegations. The record contained no investigation.	N 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 454	Continued From page 71 Resident #2 sustained a laceration to his head and bruising to this right leg and right buttock as reported on 1/3/2013 by RN Case Manager I to Administrator A. The record contained no documentation related to those injuries. Resident #2 did not have a Comprehensive Individual Service Plan addressing all of his needs. The CBRF did not maintain resident records which included: documentation of health examinations, documentation of significant incidents and illnesses, individual service plans, documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; investigations of allegations of abuse and mistreatment by a caregiver and documentation of psychotropic medication. Cross Reference: DHS 83.12(2)(a) Investigate Abuse Allegations DHS 83.12(4)(c) Reporting and Notification Requirements DHS 83.35(2) Temporary Individual Service Plan DHS 83.35(3)(a) Comprehensive Service Plan DHS 83.35(3)(d) Individual Service Plan Review DHS 83.35(5)(a) Evacuation Assessment DHS 83.37(1)(e) Psychotropic Medication DHS 83.38(1)(h) Health Monitoring	N 454		
N 487	83.44(1)(b) Separate laundry storage areas or containers Storage and transport. The CBRF shall have separate clean and dirty laundry storage areas or containers. Storage containers shall be clean, leak-proof and have a tight fitting lid. The CBRF may not transport, wash or rinse soiled laundry in	N 487		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 487	Continued From page 72 areas used for food preparation, serving or storage. This Rule is not met as evidenced by: Surveyor: 07178 Based on observation and staff interview, the CBRF did not have separate clean and dirty laundry storage areas or containers. Storage containers did not have leak-proof and did not have a tight fitting lid. Findings include: On 2/19/2013, Surveyor #07178 toured the facility. Observed in the laundry area was the following: The facility had a washer and dryer. Alongside the washer and dryer was a floor to ceiling shelf. The shelf contained a variety of blankets, sheets, towels and bed pads. On the floor directly in front of the shelf, and in contact with the shelf was an open wash basket containing dirty clothing and towels, the clothing was overflowing from the basket. A tall bin containing clothing items was alongside the dirty clothes. On 2/19/013, Surveyor #07178, #13203 and #31903 informed Administrator A of the concern that the dirty linen was in contact with clean linen and that the containers were not covered. Administrator A stated she was not aware that the containers needed to be covered. No reason was provided as to why the dirty linen was in contact with the clean linen. The facility did not have separate clean and dirty laundry storage areas or containers. Storage containers did not have leak-proof and did not have a tight fitting lid.	N 487		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 488	Continued From page 73	N 488		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Surveyor: 31903 Initially cited on standard licensure visit. Refer to SOD #9KUT11, dated 2/4/2011. Corrected on verification visit. Refer to SOD #9DUT12, dated 1/23/2012. Repeat violation, on this current standard licensure visit. Refer to SOD #IBSU12, dated 2/28/2013. Based on observation, and staff interview, it was determined that the facility did not vent the clothes dryer with rigid material as required. Findings include; The facility is licensed as a eight-person, Class CNA, non-ambulatory, community-based residential facility, that serves residents with Advanced Age and Irreversible Dementia/Alzheimer's, Mental Illness/ED, Developmentally Disabled and Physically Disabled. During tour of the facility on 2/19/13, Surveyor #31903 observed the clothes dryer was fitted with flexible aluminum venting material. Administrator A was informed of the findings at	N 488		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 488	Continued From page 74 the Exit Conference on 2/19/2013. No additional information was provided. BQA - Memo 98-024 noted dryer manufacturer's and local fire departments recommend the use of a rigid metal vent tubing for clothes dryers and frequent cleaning of the dryer's lint and the vent tubing.	N 488		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Surveyor: 07178 Based on observation and interview, the CBRF did not make reasonable attempts to keep all rooms free of odors and clean. Findings include: On 2/19/2013, Surveyor #07178 toured the facility. Noted on the ceiling fan above the kitchen table was a thick accumulation of dust and dirt debris. The screen on the patio door was torn and contained a thick accumulation of dirt. The varnish finish on the wood door frame of the patio door was worn, faded and very dull. In the resident bathroom across from the dining room, the bathroom did not have hand soap. The wood on the cabinet under the sink was water damaged and appeared rotten. The cabinet contained a jar of Vaseline. The Vaseline was not labeled for any particular resident(s). The resident bedroom located by the common resident bathroom had a heater in the room.	N 489		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 489	Continued From page 75 There were no regulator knobs to adjust the heater. The top of the heating unit contained vents. The vents were broken. The top of the unit contained dirt. In room 103, a section of the bathroom floor tile was missing. The floor in the room was very dirty. Sections of the floor contained rust-like scratches. The window blinds did not cover the patio window in the bedroom. The ceiling fan contained an accumulation of dust. One of the light bulbs on the fan did not have a cover. The closet door in the room was broken. Room 102 the floors were dirty. The walls contained numerous marks. The light fixture on the ceiling fan did not have a cover. The dry wall in the room contain multiple chipped areas. The patio window blinds did not cover the length of the window to permit privacy. The screen on the patio door was very dirty. The floor in the room was dirty. In the bathroom of room 102, the floor at the base of the toilet was rusty half way around the base of the toilet. The linoleum floor entering the bathroom was torn in a 1/2 inch by 2 inch section. Regulator knobs in the heating unit in the room were missing. Room 101 the closet door was broken. The window blinds covering the patio door were broken and did not cover the entire length of the window to permit privacy. The walls in the room were stained. The blue chair in the room contained numerous stains. The floor had an accumulation of crumbs and dirt. On 2/27/2013 Surveyor #13203 interviewed	N 489		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 489	Continued From page 76 Person M (Family Care Registered Nurse). Person M said she had been to the facility, during the week of 2/17/2013, to see Resident #3. Person M said she has concerns with the amount of bleach the facility is using to clean with. Person M said that there is always a strong odor of bleach in the facility and during the week of 2/17/2013 the odor was toxic. Person M informed the facility that they appeared to be using the wrong ratio of bleach to water. The facility was not clean and windows did not have proper coverings to ensure privacy. On 2/19/2013, Surveyors #31903, 13203 and #07178 informed Administrator A of the above findings. No additional information was provided.	N 489		
N 496	83.45(1)(e) Electrical, mechanical, water supply Systems. The CBRF shall maintain all electrical, mechanical, water supply, plumbing, fire protection and sewage disposal systems in a safe and functioning condition. This Rule is not met as evidenced by: Surveyor: 31903 Based on observation, testing of the carbon monoxide alarm and staff interview, the facility did not ensure the carbon monoxide alarm on the first floor of the facility is maintained in a safe and functioning condition. This requirement is referenced in Division of Quality Assurance Memo 11-003. Findings include: The facility is licensed as a eight-person, Class CNA, non-ambulatory, community-based residential facility, that serves residents with	N 496		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 496	Continued From page 77 Advanced Age and Irreversible Dementia/Alzheimer's, Mental Illness/ED, Developmentally Disabled and Physically Disabled. At approximately 10:10 a.m. on 2/19/13, Surveyor #31903 tested the carbon monoxide alarm on the first floor of the facility to determine if the alarm would sound while applying pressure to the test button on the carbon monoxide alarm. Administrator A was present during the testing of the alarm. Surveyor #31903 applied pressure to the test button on the alarm for a count of 30 seconds, the alarm did not sound. Administrator A stated facility services would be contacted to check the carbon monoxide alarm. Administrator A was informed of the findings at the Exit Conference on 2/19/2013. No additional information was provided.	N 496		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Surveyor: 31903 Initially cited on standard licensure visit. Refer to SOD #9KUT11, dated 2/4/2011. Corrected on verification visit. Refer to SOD #9DUT12, dated 1/23/2012. Repeat violation, on this current standard licensure visit. Refer to SOD #IBSU12, dated 2/28/2013. Based on review of the facility's emergency evacuation records and staff interview, the facility did not ensure either a tornado, flooding, or other	N 526		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 526	Continued From page 78 emergency or disaster evacuation drill was conducted at least semi-annually for the year 2012. Findings include: The facility is licensed as a eight-person, Class CNA, non-ambulatory, community-based residential facility, that serves residents with Advanced age and Irreversible Dementia/Alzheimer's, Mental Illness/ED, Developmentally Disabled and Physically Disabled. On 2/19/13, Surveyor #31903 reviewed the facility's fire drills and emergency evacuation records. The plastic sheet protector contained documentation to show a tornado drill was conducted on 6/15/11 and a bomb threat drill was conducted on 10/13/11. In 2012, there was bomb threat drill conducted on 12/29/12. There was no documentation to show evidence a second tornado, flooding, or other emergency or disaster evacuation drill was conducted in the year 2012. Administrator A was informed of the findings at the Exit Conference on 2/19/2013. No additional information was provided.	N 526		
N 530	83.47(3) Fire inspection. Fire inspection. The CBRF shall arrange for an annual inspection by the local fire authority or certified fire inspector and shall retain fire inspection reports for 2 years. This Rule is not met as evidenced by: Surveyor: 31903 Initially cited on standard licensure visit. Refer to SOD #9KUT11, dated 2/4/2011.	N 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 530	Continued From page 79 Corrected on verification visit. Refer to SOD #9DUT12, dated 1/23/2012. Repeat violation, on this current standard licensure visit. Refer to SOD #IBSU12, dated 2/28/2013. Based on record review and staff interview, the facility did not ensure an annual inspection by the local fire authority or certified fire inspector was completed annually. Findings include: The facility is licensed as a eight-person, Class CNA, non-ambulatory, community-based residential facility, that serves residents with Advanced Age and Irreversible Dementia/Alzheimer's, Mental Illness/ED, Developmentally Disabled and Physically Disabled. On 02/19/13, Surveyor #31903 requested the annual inspection of the facility by a certified fire inspector or the local fire authority from Administrator A for the years 2011 and 2012. On 2/19/13, Surveyor #31903 reviewed the documentation provided by Administrator A. During the review of inspection reports, it was noted the facility did not have evidence of a 2011 fire inspection. Surveyor #31903 also reviewed a letter dated 1/8/13 from the City of Milwaukee that noted a annual fire inspection completed on 11/29/12. The address for the property that the inspection was conducted was 8040 W. Appleton Avenue. The Ark Haven property that surveyor #31903 was reviewing is 8050 W. Appleton Avenue. There was no evidence of a annual fire inspection in 2012 for the Ark Haven property at 8050 W. Appleton Avenue.	N 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009966	A. BUILDING: _____ B. WING _____	R 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK HAVEN FOR THE ELDERLY	8050 W APPLETON AVE MILWAUKEE, WI 53218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 530	Continued From page 80 Administrator A was informed of the findings at the Exit Conference on 2/19/2013. No additional information was provided.	N 530		